

SIGNIFICANT LEGISLATIVE RULES ANALYSIS

For Rules Concerning Varicella Vaccination

Briefly describe the proposed rule.

Washington State, with a 66.6 percent vaccination rate for chickenpox among nineteen to thirty-five-month-old children, ranks very low in the nation. Comparatively, Idaho, with a 72.8 percent rate, ranks 37th and Connecticut with 93.2 percent vaccination rate, held the top spot among all states.

The proposed rule requires varicella vaccination for all children aged nineteen months to twelve years of age in Washington State. This vaccine is effective and immunization reduces illness, hospitalizations, and saves lives. The ideal would be to require immunization for all ages, but because of limited resources the age group nineteen months to twelve years children is selected at this time. Targeting child care and/or school entry requirements can provide protection to infants, adolescents, adults and persons at the highest risk for varicella virus.

“Resources”, although frequently interpreted as a pure financial concept, was used here with a broader meaning that includes semi-financial as well as non-financial resources. For example, two doses of vaccine require more resources because of the costs of vaccine (financial). It also requires an outreach program and staff to look for adolescents and adults, particularly those who don’t show up for their first or/and second follow up visits.

Varicella is a highly contagious viral illness that is transmitted by direct contact with an infected person or airborne from respiratory secretions. Varicella infection in a household member usually results in infection of almost all susceptible people in that household. Adolescents and adults are at a greater risk for severe disease and/or complications.

In addition, the proposed rule allows the Department to develop and distribute implementation guidelines for schools and child care centers to facilitate adoption and compliance with the revised rule. The Department is allowed to waive or modify immunization requirements under the rule if certain criteria are met.

Is a Significant Analysis required for this rule?

Yes.

A. Clearly state in detail the general goals and specific objectives of the statute that the rule implements.

There are a number of statutes that are relevant to this rule making effort. The general goal of the statutes is to prevent vaccine-preventable disease outbreaks in schools and child care. RCW 28A.210.080 requires each child to be fully immunized before entering child care or school. The State Board of Health is to define the substantive requirements of full immunization. WAC 246-100-166 adds varicella to the list of immunizations that constitute full immunization. RCW 28A.210.100 sets requirements for immunization records. WAC 246-100-166 details record requirements for both child care and schools.

B. Determine that the rule is needed to achieve these goals and objectives, and analyze alternatives to rulemaking and the consequences of not adopting the rule.

Revising WAC 246-100-166 is needed to add varicella as a requirement for full immunization. The current rule does not require varicella. There are no alternatives to rule-making as there is no other mechanism except revising WAC 246-100-166 to mandate varicella for schools and child care.

The consequence of not adopting the rule is to leave the decision of vaccinating children not immune to varicella to the child's health care provider and parent. The other alternative is to allow children to obtain immunity naturally by acquiring the disease. Since varicella vaccine has been made available in Washington since 1996, the use of the vaccine has been on the rise. About 66.6 percent of the children nineteen to thirty-five months of age in Washington receive the vaccine without a mandate. Because of the availability of the vaccine, fewer children are acquiring the disease and this in turn decreases the likelihood of exposure to disease. A consequence of acquiring varicella disease at an older age is the potential for more severe disease and medical complications. Mandating immunity to varicella decreases the occurrence of severe medical complications and should decrease the need for medical treatment of varicella and hospitalizations.

C. Determine that the probable benefits of the rule are greater than its probable costs, taking into account both the qualitative and quantitative benefits and costs and the specific directives of the statute being implemented.

Varicella, An Overview

Varicella (chickenpox) is a common, highly infectious disease caused by varicella zoster virus (VZV). It is characterized by fever and an itchy and blistered rash. Chickenpox-related complications are relatively rare among healthy children and in most cases, chickenpox in childhood is not life threatening. However, it can cause considerable suffering and discomfort to the patient and inconvenience to the parents. It can have serious complications such as severe skin infections, pneumonia, and encephalitis (swelling of the brain) that may result in hospitalization, or in rare cases, death. Children who suffer from chickenpox can miss valuable

time at school, which is difficult especially during exams. Parents can lose working time, spent instead in looking after their sick children

Shingles is caused by the same varicella zoster virus as chickenpox. First exposure to the virus results in chickenpox. It creates immunity against the infection which usually lasts a lifetime. The virus, however, hides in certain nerve roots and remains dormant. The virus may get reactivated many years later, leading to shingles (herpes zoster). Shingles usually afflicts adults, especially the elders, as the efficiency of their immune system declines with age.

The impact of chickenpox can be more severe and dangerous among adolescents and adults compared to children. The fever is higher and continues for a longer time. The rash is usually heavier with deeper and more lesions. The likelihood of complications is greater too. Adults are more likely to suffer from pneumonia. The chances of complications and risk to life tend to be higher when chickenpox is contracted later in life.

Because varicella is highly infectious it can create a serious public health problem. This study evaluates the costs of varicella related disease and benefits of prevention.

Cost-Benefit Analysis

Varicella is a costly disease, both medically and socially. Potential complications of the disease include pneumonia, shingles (a blistering rash), and encephalitis (an inflammation of the brain). Data from the DOH death database shows sixteen varicella related deaths during the calendar year 2003 (Table 2) and data from hospital discharge data indicates that nearly \$16 million was charged for varicella related hospitalization (Table 3). The total medical costs of disease also include doctor visits, prescription drugs, and over-the-counter remedies. Adding the costs of pain and suffering, the costs of missing valuable time at school for children, and the costs associated with loss of working time for parents of sick children makes varicella an expensive disease.

With a 66.6 percent vaccination rate for chickenpox among nineteen to thirty-five-month-old children, Washington State ranks very low in the nation. State vaccination requirement for entry into a day care or school is considered the most important factor influencing vaccination rates. Washington is one of six states that do not require it. This rule proposes requiring vaccination for children aged nineteen months to twelve years of age. By mandating vaccination for this age group, the state can enforce vaccination as a requirement of entry into a child care or school. The feasibility of accessing immunization records at these entry points and the possibility of enforcing the requirement are expected to increase vaccination rates in the state. Targeting childcare and/or school entry requirements can provide protection to infants, adolescents, adults and persons at the highest risk for varicella virus.

The purpose of this cost-benefit analysis is to evaluate and compare the benefit-cost of varicella vaccination (intervention) with the current costs of varicella related disease (no intervention). Costs due to varicella are mostly attributed to medical costs (including hospitalization, physician visit, and medication), costs of life lost, costs of pain from disease symptoms and suffering from lost important school days for children, and lost parental work days to take care of sick children

at home. Although societal costs for uncomplicated varicella are less than for complicated cases, uncomplicated cases are responsible for the major part of the overall economic burden.

Methodology and Data

Decision analysis was used to compare the costs and benefits of a routine vaccination program with no intervention. Children nineteen months to twelve years of age with negative or uncertain history of chickenpox disease would be identified at the point of entry to child care or school and would be required to show documentation of vaccination or serological testing.

We assume one dose of varicella vaccine is needed for children twelve years and younger. We assume that vaccine efficacy would be one hundred percent, and vaccine-induced immunity would be lifelong. We also assume that it takes at least a week of working parents' time to look after their sick kids at home. Costs and benefits of vaccination are compared with the current costs of varicella related disease in this cost benefit analysis. Costs and benefits are measured in 2003 dollars.

Costs associated with vaccination (intervention) are the costs of vaccine and costs of vaccine implementation. Although varicella vaccine implementation involves some costs, it can be implemented along with other vaccine or during a routine visit. For this reason we considered two possibilities of zero (best case) and nonzero costs (worse case) when calculating the vaccine implementation cost.

Benefits associated with vaccination (intervention) are defined as current costs of varicella related disease. These are future costs that will possibly be avoided as a result of vaccination. Current costs of varicella are estimated in two categories of medical and societal costs in this analysis.

Among medical costs, hospitalization is the only one that is estimated here because costs of physician visits and medication are not available. Among societal costs only the value of loss of work hours to parents are estimated here. The costs of symptoms, pain and suffering to children and the costs of varicella related death are not included in this study. Including the costs of one or two hours of parents' time to have child vaccinated will not change our conclusion.

Hospitalization data are from the Washington State hospital discharge database. Hospital charges are discounted to represent the approximate costs of hospitalization. Benefits or future hospital cost avoidance of vaccination can be defined in two ways. Vaccination of children nineteen months to twelve years of age children could be assumed to reduce or eliminate the costs of hospitalization only for this age group. On the other hand, since varicella among children of this age group is responsible for the spread of disease among adults, it would be plausible that vaccination of this age group would reduce or eliminate all hospitalization costs. For this reason we considered two possibilities of worst case (hospital costs elimination for only vaccinated group) and best case (hospital costs elimination for all age groups).

The projected number of children to be immunized are provided by the Department of Health (DOH) immunization program. The total population is grouped in five age cohorts and a catch up group as shown in Table (1) below:

A. Table (1), Projected Children to be Immunized

	12 to 23 Months	2 to 4 Years	5 to 9 Years	10 to 12 Years	Catch up Group	All Ages
Base Population	80,000	239,066	410,544	268,116	10,000	1,007,726
% to be Immunized	80%	10%	10%	10%	100%	
Total to be Immunized	64,000	23,907	41,054	26,812	10,000	165,773

Source: DOH Immunization Program

Results

Costs – Vaccination

One dose of varicella vaccine is recommended for children twelve years and younger. The unit cost of vaccine is \$52.25. Costs of vaccine administration could fluctuate from zero (if administered with other vaccines as part of office visit) to \$10 (according to Kim Thorburn, health officer with the Spokane Regional Health District. “Patients pay for the office visit or administrative fee, typically \$10”) from “Washington Rates Last for Chickenpox Shot”, an article published in [The Spokesman-Review.com](http://TheSpokesman-Review.com), April 20, 2005.

We assume here that vaccine efficacy would be one hundred percent, and that vaccine-induced immunity would be lifelong and therefore zero costs associated with varicella infection after vaccination. Clinical studies of currently available varicella vaccines show they are close to one hundred percent effective. The efficacy in normal children, who were exposed to wild-type varicella virus in the first year after vaccination, has been estimated in two randomized placebo-controlled trials to be one hundred percent and eighty-eight percent respectively. Several other studies have reported that each year post vaccination, one to three percent of vaccinated children develop a mild varicella disease. These breakthrough infections are generally mild, with few skin lesions and do not result in dissemination or serious illness.

Future Possible Benefits – Current Societal Costs – Symptoms, Pain and Suffering

Chickenpox is very uncomfortable for patients because they have to endure symptoms such as rash and the associated itching, fever, chills, nausea and vomiting. Patients often need to be isolated and kept at home. Thus, a school-age child may miss school days at least for a week. In adolescents and adults, chickenpox can be more serious and severe, with the increased severity sometimes leading to complications. In some cases there may be residual scarring. As a result, chickenpox infection can lead to loss of man-hours in the form of missing school, college or working time. Since estimation of these costs are non-trivial and would require extended research, we didn’t include these costs (future benefits) in our analysis.

Future Possible Benefits - Current Societal Costs – Loss of Work Hours to Parents

In households where both parents work, varicella might require one of them to stay home to care for the child and thus miss work. The incubation period for varicella virus averages fourteen to sixteen days. The period of infectiousness begins one to two days before the onset of rash and

ends when the lesions are crusted, which is four to five days later. We assumed that it takes at least a week of working parents' time to care for a sick child at home.

We used \$33,370 as the average annual income for a working parent in the 2003 dollars as the basis of our calculation. The number comes from \$32,661, the "income per capita" for the year 2002, published in 2003 Washington State Data Book. An inflation factor = 1.027 was applied to the 2002 number to arrive at \$33,370 for the year 2003. A weekly equivalent of this annual figure $33,370 / 52$ or \$642 was used as the opportunity costs of one week of work loss (earnings) for a working parent taking care of a sick child.

Future Possible Benefits - Current Societal Costs – Death

Table (2) shows the number of varicella related death for the two years 2000 and 2003. Varicella is listed as the underlying cause of death and also as a contributing cause of death in the table. As the first row of the table indicates, the number of deaths caused by varicella dropped from six in 2000 to two in 2003. However, the total number of deaths caused and contributed by varicella did not significantly change over time.

The minimum age of death was greater than forty-five years of age during these two years. The table clearly shows that varicella related death took place at later age, typically among patients ages eighty years or older. The pattern of varicella related death may have shifted because of the availability and implementation of varicella vaccination. During the years before the varicella vaccine was licensed, most deaths occurred among persons younger than twenty years of age and children younger than one year. This analysis does not include the value of life.

Table (2), Washington Residents Death Record

UCD = Varicella as underlying cause of Death

CCD = Varicella as Contributing cause of Death

TOTAL = UCD + CCD

Death Age (Year)	2000 UCD	2003 UCD	2000 CCD	2003 CCD	2000 TOTAL	2003 TOTAL
All Ages	6	2	9	14	15	16
45 to 49	-	-	1	-	1	-
50 to 54	-	-	-	-	-	-
55 to 59	-	-	-	-	-	-
60 to 64	-	-	1	-	1	-
65 to 69	-	-	-	-	-	-
70 to 74	-	-	1	-	1	-
75 to 79	-	-	-	1	-	1
80 to 84	1	-	1	2	2	2
85 to 89	2	1	-	6	2	7
90 to 94	2	-	1	4	3	4
95 to 99	1	1	3	1	4	2
100 to 105	-	-	1	-	1	-

B. Future Possible Benefits - Current Costs – Hospitalization

Tables (3) and (4) present hospital statistics for different age groups, average length of hospitalization, and average hospital stay charges during the two calendar years 2000 and 2003. As the table indicates, the average number of hospitalizations declined for all children under ten years of age over time. For the age group ten to twelve years, it remained unchanged, declined for the thirteen to eighteen years old group, and increased for those nineteen years and older. However, the figures for average length of stay and average costs do not show the same clear and consistent pattern. Assuming costs and length of stay represent the severity of illness, the average cost figures in Table (3) support the general positive correlation between age and severity of disease.

Tables (3) and (4)

Varicella Hospitalization Statistics for Selected Age Groups

Time Period : CY 2000 and CY 2003

Source: Hospital Discharge Data

Table (3), Average Length of Stay and Average Total Charges

AGE	No. of Patients CY 2000	No. of Patients CY 2003	Avg Charges CY 2000	Avg Charges CY 2003	Avg Lstay CY 2000	Avg Lstay CY 2003
12 to 23 m	12	7	10,599	7,928	4	4
2 to 4 y	23	10	6,472	14,477	3	6
5 to 9 y	30	25	10,173	9,245	4	4
10 to 12 y	8	8	7,916	30,289	4	9
13 to 18	20	7	6,893	11,072	4	6
>= 19 y	890	988	11,761	15,097	6	5
ALL	983	1,045	11,444	14,992	6	5

Table (4), Length of Stay and Total Charges

AGE	No. of Patients	No. of Patients	Total Charges	Total Charges	Total Lstay	Total Lstay
	CY 2000	CY 2003	CY 2000	CY 2003	CY 2000	CY 2003
12 to 23 m	12	7	127,185	55,494	50	26
2 to 4 y	23	10	148,850	144,765	70	55
5 to 9 y	30	25	305,189	231,127	125	106
10 to 12 y	8	8	63,328	242,315	35	72
12 m to 12 y	73	50	644,552	673,701	280	259
13 to 18	20	7	137,862	77,507	80	39
>= 19 y	890	988	10,467,170	14,915,759	5,053	4,938
ALL	983	1,045	11,249,584	15,666,967	5,413	5,236

Cost Savings

Table (5) shows the results of cost-benefit analysis for vaccinating all children nineteen months to twelve years old and for each of the five age groups. Benefits associated with vaccination (intervention) are defined as future- avoidable current costs of varicella related disease. Hospital charges are thirty percent discounted to approximate the true costs of hospitalization. Under the best case scenario, the \$10,966,877 hospital costs (\$15,666,967 hospital charges) of all age groups for the year 2003 were allocated to the five projected vaccination age groups on the basis of their projected number of vaccinations (projected number of children to be vaccinated). This best case scenario allocation was based on the assumption that vaccination of children ages nineteen months to twelve years could possibly eliminate the incidences and costs of all future hospitalization. Under the worst-case scenario, only the total \$471,591 hospital costs of the projected vaccination age groups are considered.

These hospitalization costs are considered to be the avoidable future costs and are counted as the benefits of vaccination program. The costs of lost work hours for parents are also considered as an avoidable future cost and counted as the societal benefits of vaccination program. On the cost side, the costs of vaccine at \$52.25 and the costs of vaccine administration under both best and worst scenarios are counted and compared with the benefits of the vaccination program.

Three net benefit figures and benefit-cost ratios are calculated for the proposed varicella vaccination program. As presented in Table (5), the first two are calculated for the best and worst case scenarios from the societal point of view. The \$108,731,268 net benefit figure for all children under the best scenario suggests that the proposed vaccination program is cost effective from a societal point of view. Future possible gains for parents' work loss time accounts for ninety percent of the total net benefits. The benefit-cost ratio for this scenario indicates that Washington State gains fourteen dollars for each dollar spent. The \$41,977,994 net benefits for the nineteen to twenty-three months age group is the highest among all vaccination groups.

The \$96,578,256 net benefit figure for all children under the worst scenario also suggests that the proposed vaccination program is cost effective from a societal point of view. The benefit-cost ratio for this scenario indicates that Washington State gains ten dollars for each dollar spent. The \$37,142,846 net benefits for the nineteen to twenty-three months age group is the highest among all vaccination groups.

The last group of figures in the table shows the net benefits and benefit-cost ratio from health plan or insurance point of view. The \$2,776,849 net benefit figure for all children under the best scenario also suggests that the proposed vaccination program is cost effective from the health plan / insurance point of view. Future possible gains for parents' work loss time are not included in this benefits calculation. The benefit-cost ratio for this scenario indicates that Washington State gains \$1.32 for each dollar spent.

Table (5), Benefit-Cost Analysis for Varicella Vaccination in 2003 Dollars

	19 to 23 Months	2 to 4 Years	5 to 9 Years	10 to 12 Years	Catch up Group	<= 12 and Catch up
Children to be Immunized	64,000	23,907	41,054	26,812	10,000	165,773
	\$	\$	\$	\$	\$	\$
Benefits (avoidable Costs)						
Hospital Costs (Best Case)	4,233,994	1,581,569	2,716,001	1,773,752	661,561	10,966,877
Hospital Costs (Worst Case)	38,846	101,336	161,789	169,621		471,591
Work Lost Costs	41,088,000	15,348,037	26,356,925	17,213,047	6,420,000	106,426,009
Costs (Vaccination Costs)						
Vaccine Costs	(3,344,000)	(1,249,120)	(2,145,092)	(1,400,906)	(522,500)	(8,661,618)
Vaccine Admin (Best Case)	0	0	0	0	0	0
Vaccine Admin (Worst Case)	(640,000)	(239,066)	(410,544)	(268,116)	(100,000)	(1,657,726)
Social Benefits-Costs						
Benefits (Best Case)	45,321,994	16,929,606	29,072,926	18,986,799	7,081,561	117,392,886
Costs (Best case)	(3,344,000)	(1,249,120)	(2,145,092)	(1,400,906)	(522,500)	(8,661,618)
Net Benefits	41,977,994	15,680,486	26,927,833	17,585,893	6,559,061	108,731,268
Benefit-Cost Ratio						14
Social Benefits-Costs						
Benefits (Worst Case)	41,126,846	15,449,373	26,518,714	17,382,668	6,420,000	106,897,600
Costs (Worst case)	(3,984,000)	(1,488,186)	(2,555,636)	(1,669,022)	(622,500)	(10,319,344)
Net Benefits	37,142,846	13,961,187	23,963,077	15,713,646	5,797,500	96,578,256
Benefit-Cost Ratio						10
Health Plan Benefits-Costs						
Benefits (Best Case)	4,272,839	1,682,904	2,877,790	1,943,373	661,561	11,438,468
Costs (Best case)	(3,344,000)	(1,249,120)	(2,145,092)	(1,400,906)	(522,500)	(8,661,618)
Net Benefits	928,839	433,784	732,698	542,467	139,061	2,776,849
Benefit-Cost Ratio						1.32

Concluding remarks

The findings of this cost-benefit analysis suggest that the Washington State proposed vaccination program is cost effective and is a valuable social investment. The findings show that the program not only is cost effective from a societal point of view but also is cost effective from the insurance and health care costs viewpoint. The 1.32 benefit-cost ratio suggests that the future benefits from avoiding only the hospital costs under the best case scenario is sufficient enough to offset the total costs of vaccination program. This savings does not include other chicken pox potential costs, such as doctor visits, prescription drugs, over-the-counter remedies, costs of pain and suffering for children and loss of lives, all of which are also expected to be reduced or eliminated as a result of the chicken pox vaccine.

Although varicella related symptoms are more severe among adults and represent a major health threat, vaccination of young children can work as a vital and pro-active strategy for controlling the situation. Vaccination of children can reduce the disease burden and transmission of varicella related disease. This would also result in avoiding the social impact of the disease and reducing healthcare costs.

The findings of this cost-benefit analysis are based on certain assumptions such as the one hundred percent effectiveness of varicella vaccine and its lifelong immunity. These assumptions can be relaxed and probability figures can be developed and the cost-benefit analysis can be estimated based on other sets of assumptions. However, the results seem to be robust from the societal point of view and insensitive to new assumptions.

D. Determine, after considering alternative versions of the rule, that the rule being adopted is the least burdensome alternative for those required to comply with it that will achieve the general goals and specific objectives stated previously.

Those required to comply are

- Children seeking admission into child care and their parents
- Children seeking entry into kindergarten and their parents
- Children through twelve years of age are also required to show immunity from varicella.
- School administrators are responsible for monitoring the immunization status of children in school and completing reporting requirements to the DOH
- Child care providers are responsible for monitoring full immunization requirement of children attending their facilities as well as reporting requirements to the DOH.

The general goal and objectives of the underlying statute are to promote the prevention of vaccine-preventable diseases among children who are most susceptible to the disease and its complications.

Mandating varicella for child care, kindergarten entry, and children entering sixth grade is the recommended option and will be reflected in draft rule language. Most children of child care age will receive the recommended vaccinations as part of their routine well child visits. By kindergarten entry, most children are fully immunized. Varicella could easily be added into the list of vaccines children receive. Children twelve years of age are at greater risk for severe disease and/or complications.

Alternative versions of the rule offered different methods of implementation. Alternative versions of the rule are as follows:

1. Mandating varicella immunity for child care and kindergarten entry. This increases immunity against varicella among children up to five years of age. Adding a varicella requirement should not add significant burden to school and child care administrators as children receive a number of vaccines between the birth and five years of age. School and child care administrators already promote immunization and require proof of immunization

of other antigens at this age. Varicella would merely be an addition to that requirement. Although this option is less burdensome administratively for schools and child care, it does not address the need to prevent varicella in older children who have not acquired natural immunity. Older children who acquire varicella disease later in life risk higher complications from the disease and their parents are more at risk for missing hours of work and responsibility for higher medical costs if their children experience medical complications.

2. Mandating varicella for kindergarten only. Excluding child care removes any burden associated with mandating varicella in rule for child care providers. However, young children are susceptible to the disease. This option neither addresses the burden these children and their parents experience if the disease is acquired naturally, nor the burden of older children and their parents who experience disease later in life. In addition, ACIP recommends that children be vaccinated at twelve to eighteen months.
3. Mandating varicella for middle school entry, emphasizing children within the age range of eleven to thirteen years. Although this curtails the risk older children face that risk varicella disease at a later age and focuses the administrative burden on sixth to eighth grade in schools, it does not prevent the risk of disease among susceptible children less than five years of age in child care or those entering kindergarten.
4. Mandating school and child care for all ages. This would likely raise protection against varicella among children of all ages. However, there would be a much larger administrative burden upon schools to screen for varicella among all ages.
5. Implementation date for the varicella requirement. The rule specifies that it will be effective July 1, 2006. This allows schools and child care to provide the necessary education and notification of the rule requirements to parents before a mandate is established. The default time frame from implementation, thirty days from adoption of the rule, does not allow time for a preceding period of parent education and notification and schools and child care would be hard pressed to implement the rule by the 2005-2006 school year.
6. Implementation date for section 8. The Department proposes that section 8 be effective thirty days after adoption. This section allows for the Department to develop and distribute implementation guidelines for schools and child care centers to facilitate adoption and compliance with the revised rule. In addition, the Department is allowed to waive or modify immunization requirements under the rule if certain criteria are met. This way, section 8 allows for efficient collaboration between the board and the department as well as ensures accountability whenever waiver or modification is needed.

E. Determine that the rule does not require those to whom it applies to take an action that violates requirements of another federal or state law.

Not applicable.

F. Determine that the rule does not impose more stringent performance requirements on private entities than on public entities unless required to do so by federal or state law.

Private entities that are affected here are private schools and private health care providers. The varicella vaccine is already available to private health care providers and a school entry requirement should not impose more stringent performance on providers. In addition, nothing in this rule imposes different requirements for private schools in comparison to public schools thus private schools are not faced with more stringent performance requirements than public schools.

G. Determine if the rule differs from any federal regulations or statute applicable to the same activity or subject matter and, if so, determine that the difference is justified by an explicit state statute or by substantial evidence that the difference is necessary.

Each state determines what immunizations are required for school entry. Federal law requires that health care providers give information to parents about immunizations their child is to receive. Child care and school entry immunization mandates are solely under the jurisdiction of state law.

H. Demonstrate that the rule has been coordinated, the maximum extent practicable, with other federal, state, and local laws applicable to the same activity or subject matter.

As mentioned in Section A, there are a number of statutes that are relevant to this rule making effort. The Department of Health and the State Board of Health are working with the Attorney General's Office as well as other State agencies that have statutory authority affected by this rule making effort. State agencies include the Office of the Superintendent of Public Instruction, the Department of Social and Health Services, and the State Board of Education.

There are federal laws applicable to the same activity or subject matter. Federal law requires health care providers to give information to patients about immunizations they receive. In addition, federal guidance is issued yearly in the form of the recommended childhood and adolescent immunization schedule as published by the ACIP. The ACIP recommends that children and adolescents receive immunization against varicella. As mentioned earlier, individual states determine what immunizations are required for school entry and child care.